Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,560.00 for dates of service, 10/16/01, 10/17/01, 10/18/01 & 10/19/01.

   b. The request was received on 02/21/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/12/02. There is no response from the Requestor in the file. A "No Additional Information Received" from the Requestor is reflected in Exhibit I.
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/12/02. There is no Carrier initial or 14 day response to this medical fee dispute in the file, evidently due to the fact no response to the notice was received from the Requestor.

III. PARTIES' POSITIONS

1. Requestor: Letter undated
   ""…We based our fair and reasonable charges for CPT Code 97799-CP for all the components required to carry our Chronic Pain program…. This eight-hour program is an extensive, coordinated, goal-oriented, with an interdisciplinary team that provides services to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain syndrome. The program was set up to reduce the patient's dependence and/or addiction to the pain medications….It was due to this

intensity of the program, that we believe that the charge is a fair and reasonable charge of the Chronic Pain Program"

2. Respondent: No position statement

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are, 10/16/01, 10/17/01, 10/18/01 & 10/19/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
10/16/01 10/17/01 10/18/01 10/19/01	97799 CP 97799 CP 97799 CP 97799 CP	$1600.00 $1600.00 $1600.00 $1600.00	$960.00 $960.00 $960.00 $960.00	M for all dates	DOP for all dates	MFG General Instructions (III); MGR (II) (G); CPT Descriptor	The carrier has denied the charges in dispute as "M – REIMBURSED PER THE INSURANCE CARRIER/S FAIR AND REASONABLE ALLOWANCE". The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed. There is no medical documentation in the file to support that services were rendered. N**o** reimbursement is recommended
Totals		$6400.00	$3840.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 8th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.